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DIALYSIS CLINIC INC - ELKO	1995 ERRECART BLVD 100 - 101 ELKO, NV 89801

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V 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a Medicare recertification survey conducted at your facility on 11/17/08 through 11/21/08. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Four clinical records were reviewed. Three patients were interviewed. The agency failed to maintain condition level compliance with the following Conditions of Participation: 42 CFR 494.30 - Infection Control 42 CFR 494.140- Personnel Qualifications	V 000		
V 110	494.30 INFECTION CONTROL This CONDITION is not met as evidenced by: The facility: failed to clearly defined clean versus dirty areas (V0117); failed to ensure the appropriate storage of clean supplies (V0119); failed to ensure the appropriate handling, storage and disposal of potentially infectious waste (V0121); failed to ensure the appropriate cleaning and disinfecting of contaminated surfaces (V0122); failed to ensure the vaccination of patients and staff against Hepatitis B (V0126); failed to provide employee training for infection control (V0132); and failed to ensure	V 110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 110	Continued From page 1	V 110		

medications for patients were not expired (V0143).

The cumulative effect of these systemic practices resulted in the failure of the agene to deliver statutorily mandated care to its patients.

Based on observation, interview and record review of facility records, logs and policy, the facility failed to provide and pursue a comprehensive and active infection control program.

Findings include:

Review of the Policy and Procedure Manual for the facility revealed that the section titled Infection Control was empty. Attempts made by the Regional Administrator and the Unit Secretary did not produce any of the missing policies. The facility Nurse Manager had left approximately six weeks previously and staff were not aware of where many of the files might be located. At the time of the survey, no one on site was responsible for the Infection Control Program.

The Patient Infection Control Flowsheet did not consistently indicate if cultures were obtained or did it indicate the pervasive organism. Specific antibiotics, duration of treatment or the effectiveness of the treatment were not always indicated.

In an interview with Employee #2 on 11/17/08, she indicated that she was not aware that new regulations had been adopted by the Centers for Medicare and Medicaid for End-Stage Renal Disease Facilities, effective October 14, 2008,

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V 110	Continued From page 2 that included new regulations for Infection Control.	V 110		
V 117	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to clearly designate clean and dirty areas in the patient care areas. Findings include: Observations on 11/17/08, 11/08/08, 11/19/08 and 11/20/08, revealed the following: 1. Dirty cover-up gowns used by staff were discarded in a hamper in the public bathroom on	V 117		

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V 117	Continued From page 3	V 117		

the unit. This hamper was next to the rack that clean, unused cover up gowns were stored. These clean gowns were covered with individual plastic, dry cleaning type coverings that was not resistant to tearing.

2. A clean supply cart and supplies was located next to a biohazard waste container and a kidney dialysis machine that was in use all four days of observation. Both were within 18 inches of the clean supply cart. The clean supply cart was uncovered.

3. Cover up gowns that were in use were hung on hooks which were located next to the same clean supply cart. These gowns were hung directly above a biohazard waste container. It was also observed on one occurrence, that the cover up gowns were draped over the biohazard container lid and sides.

4. A sink and counter was located at the side of the nurses station. This was divided from the nurses station by a Plexiglass barrier approximately 12 inches high. This barrier had a sign "dirty" posted. On 11/17/08, nursing staff were observed to place a rack for blood specimens on the this counter. The nurses also indicated this was where the blood specimens would be centrifuged. It was also observed during all four days a supply cart was stored next to this counter. This cart contained special dialysate mixtures as well as sterile and clean supplies for the kidney machines that were prepared for the next schedule of treatments.

Interviews with staff during the four days revealed that staff could not identify whether the whole counter was a dirty counter or just the sink. Staff

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V 117	Continued From page 4 also acknowledged that the clean supplies could be contaminated by either trash being discarded in the biohazard containers or from the kidney dialysis machine.	V 117		
V 119	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies. Do not carry medication vials, syringes, alcohol swabs or supplies in pockets. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain clean supplies a significant distance away from patient care areas to avoid contamination with blood. Findings include: Observations of the patient care areas revealed that Patient Care Chair #5 was located approximately three feet from an open, multi-shelf supply storage unit. This unit was uncovered. The supplies stored were intravenous solutions used to run in the dialyzer machines, and other direct patient care items. The dialyzer machine used for treatments was in the space between the Patient Care Chair #5 and the open supply storage unit. Observations of the nursing staff disposing of the used and contaminated dialyzer and tubing used by any patient who used Chair #5 were doing so	V 119		

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V 119	Continued From page 5 within approximately six to twelve inches of the clean supplies. An interview with the Administrator on 11/20/08, revealed the closed cabinet above the open storage unit could be used to store these supplies and would prevent or minimize a possible contamination of blood particles reaching the clean supplies.	V 119		
V 121	494.30(a)(4)(i) PROCEDURES FOR INFECTION CONTROL [The facility must demonstrate that it follows standard infection control precautions by implementing-] (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the- (i) Handling, storage and disposal of potentially infectious waste; This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper disposal of biohazard waste. Findings include: An observation at 6:00 AM on 11/18/08, revealed no biohazard plastic bag liners were placed in the two metal biohazard containers used for discarded biohazard supplies. The two registered nurses and the two patient care technicians on duty at the time all confirmed they had not noticed the lack of plastic liners. They also stated the night cleaning crew were to place the plastic liners in the containers.	V 121		

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V 121	Continued From page 6 An observation at 3:30 PM on 11//20/08, revealed a waste container between Chairs #2 and #3 that was partially filled with paper trash. Three disposable gloves and miscellaneous trash were observed on the floor surrounding the waste container. Patient care staff were observed to use the disposable gloves whenever they had direct contact with the patient, the patient's venous access, used tubing, and the machine clean-up.	V 121		
V 122	494.30(a)(4)(ii) PROCEDURES FOR INFECTION CONTROL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to clean all surfaces without visible blood with a low level disinfection protocol at the end of each dialysis treatment. Findings include: During an observation of the unit on 11/17/08, and 11/18/08 in the early morning and near the closing time of the unit, it was noted that the plastic containers for the bicarbonate were crusted with dried material from the liquid inside. The jugs had not been dated as to when they had been filled. The cart used to transport the jugs	V 122		

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V 122	Continued From page 7 from the water treatment room to the dialysis treatment room contained some of the same crusted material. When Employee #6 was interviewed, she stated that the jugs were supposed to be wiped down every day.	V 122		
V 126	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE Hepatitis B Vaccination Vaccinate all susceptible patients and staff members against hepatitis B. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide Hepatitis B vaccinations per protocol to susceptible patients and staff. (Patients #2, #3) (Employees #2, #4, #5) Findings include: Clinical record reviews revealed the "Hemolysis Standing Orders" that included "#13: Annual Updates:... the Hepatitis B vaccine to those patients who remain antibody negative... with appropriate consent form signed." Patient #2 was admitted to the facility on 3/7/06. Review of the clinical record revealed that Patient #2 received a Hepatitis vaccine injection on 9/2/08. This was identified as the first injection of the second series. She did not receive her second injection that was due one month after the first on 10/2/08 and the third injection that was due two months after the first on 11/2/09. An antibody titer test was due 11/13/08. There was no record of the test on the chart, but the form indicated the test was positive.	V 126		

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V 126	Continued From page 8 Patient #3 was admitted to the facility 1/06/02. There was no evidence if or when Patient #3 received the Hepatitis B vaccine. The review of five employee records revealed the following: Employee #2 was hired in September 2008. Her personnel record revealed she signed a consent of acceptance to receive the Hepatitis B vaccine. There was no evidence in her personnel file, that she ever received the vaccine. There was no evidence of any lab work to determine whether she had any Hepatitis B antibodies present. An interview with Employee #2 on 11/18/08, revealed that the Nurse Manager went on medical leave the day after Employee #2 started. An interview with the Administrator on 11/20/08, confirmed that the current Nurse Manager was on medical leave, and that she was probably the person who administered the Hepatitis vaccine to staff. He stated he was not aware if anyone had been assigned this responsibility in the interim. Employee #4 was hired in December 2007. Her personnel record revealed she signed a consent of acceptance to receive the Hepatitis B vaccine. There was no evidence in her personnel file that she ever received the vaccine. There was no evidence of any lab work to determine whether she had any Hepatitis B antibodies present. Employee #5 was hired in May 2007. Her personnel record revealed she signed a consent of acceptance to receive the Hepatitis B vaccine. There was no evidence in her personnel file that she ever received the vaccine. There was no evidence of any lab work to determine whether	V 126		

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V 126	Continued From page 9 she had any Hepatitis B antibodies present. There was also evidence that Employee #5 had a needle stick exposure on 9/28/07, but there was no evidence that a Hepatitis test was performed at the time or that the employee had received the Hepatitis vaccine.	V 126		
V 132	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE Infection Control Training and Education Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices. This STANDARD is not met as evidenced by: Based on review of personnel records, the facility failed to provide evidence of initial and/or annual education of infection control training for 2 of 5 employees. (#2, #4) Findings include: Employee #2 was hired in September 2008. There was no evidence in the personnel record that this employee received infection control training by the facility. Employee #4 was hired in December 2007. There was no evidence in the personnel record that the employee received infection control training by the facility. An interview with the Administrator on 11/20/08, revealed that the staff were required to complete monthly computer training. He acknowledged	V 132		

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V 132	Continued From page 10 these were corporate training modules, not specific to this facility. He acknowledged that the Nurse Manager had been responsible for monitoring training, but had been on medical leave since September. The Administrator acknowledged that he did not know who was monitoring training in the Nurse Manager absence.	V 132		
V 143	494.30(b)(2) OVERSIGHT [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that expired medications were not available for use. Findings include: During observation of the unit at 1:50 PM on 11/17/08, the medication refrigerator contained the following: - One open vial of Epogen without being dated when opened. - One open vial of influenza vaccine without the date when opened indicated. In an interview with Employee #2, she stated that all vials should be dated when opened and discarded after 28 days.	V 143		
V 454	494.70(a)(3) PATIENTS' RIGHTS	V 454		

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V 454	Continued From page 11 [The patient has the right to-] (3) Privacy and confidentiality in all aspects of treatment; This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide privacy during the physical care of two unsampled patients. (#5, #6) Findings include: When entering the unit at 1:50 PM on 11/17/08, Patients #5 (female) and #6 (male) were observed being dialyzed through central lines located in their chest areas. When the two patients were taken off the dialysis machines a short time later, there was no attempt to provide the patients with any privacy from the other patients while disconnecting their dialysis lines from the catheters located in their chest. When interviewed a short time later, Employee #3 stated that she did not know that privacy should be provided.	V 454		
V 455	494.70(a)(4) PATIENTS' RIGHTS [The patient has the right to-] (4) Privacy and confidentiality in personal medical records; This STANDARD is not met as evidenced by: Based on observation, the facility failed to protect the patients' right to confidentiality of their medical records. Findings include:	V 455		

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V 455	Continued From page 12 Dividing the nurses station from the main unit was a Plexiglass barrier approximately 12 inches high. On 11/17/08 through 11/21/08, a list of the patients receiving dialysis treatments that day was observed taped on the barrier. The list included the type of potassium bath the patients were on as well as their dialyzer. This information was visible to anyone entering the unit.	V 455		
V 456	494.70(a)(5) PATIENTS' RIGHTS [The patient has the right to-] (5) Be informed about and participate, if desired, in all aspects of his or her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental research; This STANDARD is not met as evidenced by: Based on record review, patient interview and staff interview, the facility failed to involve patients in their plans of care for 2 of 4 patients. (#3, #2) Findings include: Patient #3 was admitted to the facility 1/06/02. Her primary diagnoses included diabetes and end stage renal disease. The clinical record revealed a short term care plan that was revised on 9/24/08. The form contained the final statement "The above care plan has been discussed with me and I have received information. My questions have been answered to my satisfaction." The form had a space for either the patient or designee to sign and date. The form was not signed by the patient or designee.	V 456		

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V 456	Continued From page 13 Patient #2 was admitted to the facility on 3/7/06, with the primary diagnoses of diabetes and end stage renal disease. She was interviewed on 11/18/08 at 8:30 AM. She stated that no staff had ever instructed her on her plan of care. No patient signatures were found on her short term care plans. She stated she had never been invited to any care plan meeting. Review of the clinical record revealed a short term care plan for Patient #2 was done on 5/15/08. This care plan had no third page which was the signature sheet. An interview with the Co-medical Director on 11/20/08 at approximately 9:00 AM, confirmed she would speak to patients about their care, but did not identify this as part of their plan of care. She stated that she and the Nurse Manager would meet and discuss the various patients. She confirmed the patients were not invited to any formal care conferences. A telephone interview with the social worker at approximately 11:00 AM on 11/19/08, confirmed she did not normally attend care plan meetings or discuss the plan of care with the patients.	V 456		
V 465	494.70(a)(14) PATIENTS' RIGHTS [The patient has the right to-] (14) Be informed of the facility's internal grievance process; This STANDARD is not met as evidenced by: Based on interviews, record review, and observation the facility failed to provide evidence	V 465		

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V 465	Continued From page 14 that patients were informed of the facility's internal grievance process for 2 of 4 patients. (#2, #3) Findings include: An interview with the unit receptionist 11/19/08, revealed that the facility had an admission packet that contained consents and information for all patients. This packet included an acknowledgement form that was to be signed by the patient to indicate the patient had received the internal grievance process information. Patient #2 was admitted to the facility on 3/7/06. She was interviewed on 11/18/08 at 8:30 AM. She stated she was not aware of the internal grievance procedures. She would let her physician or a staff member know if there was a problem. There was no signed acknowledgements in her clinical record to demonstrate that she had received the facility's internal grievance procedures. She stated she would contact the social worker if she had any grievances. Patient #3 was admitted to the facility 1/06/02. There was no signed acknowledgements in her clinical record to demonstrate that she had received the facility's internal grievance procedures Observations of the lobby area on 11/17/08, 11/18/08, 11/19/08 and 11/20/08, revealed no posted information regarding the internal grievance process. An interview was conducted with the social worker at approximately 11:00 AM on 11/19/08. The Social Worker denied any knowledge that	V 465		

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V 465	Continued From page 15 she was identified as the grievance officer. The social worker did provide documentation of a grievance that originated with a patient in July 2008. The patient notified the corporate office expressing a desire to file a grievance. The patient was instructed by the corporate office to contact the social worker first. An interview with the Administrator at 8:00 AM on 11/20/08, revealed the grievance information had been removed from the lobby posting. Staff were unaware the information had been removed.	V 465		
V 466	494.70(a)(15) PATIENTS' RIGHTS [The patient has the right to-] (15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State survey agency; This STANDARD is not met as evidenced by: Based on interviews, observation and record review, the facility failed to inform patients of the external grievance mechanisms and processes for 2 of 4 patients. (#3,#2) Findings include: An interview with the unit receptionist on 11/19/08 revealed the facility had an admission packet that contained consents and information for all patients. This packet included an acknowledgement form that was to be signed by the patient to indicate the patient had received the external grievance process information. Patient #3 was admitted to the facility 1/06/02.	V 466		

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V 466	Continued From page 16 There was no signed acknowledgements in her clinical record to demonstrate that she had received the facility's external grievance procedures Patient #2 was admitted to the facility on 3/7/06. There was no signed acknowledgements in her clinical record to demonstrate that she had received the facility's external grievance procedures. Interview with Patient #2 on 11/18/08, revealed this patient would contact the social worker if she had any grievances. She was not aware of the ESRD network or state grievance process. Observations of the lobby area on 11/17/08, 11/18/08, 11/19/08 and 11/20/08, revealed no posted information regarding the external grievance process. An interview with the Administrator at 8:00 AM on 11/20/08, revealed the grievance information had been removed from the lobby posting. Staff were unaware the information had been removed.	V 466		
V 467	494.70(a)(16), (17) PATIENTS' RIGHTS [The patient has the right to-] (16) Be informed of his or her right to file internal grievances or external grievances or both without reprisal or denial of services; and (17) Be informed that he or she may file internal or external grievances, personally, anonymously or through a representative of the patient's choosing. This STANDARD is not met as evidenced by:	V 467		

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V 467	Continued From page 17 Based on interview, observation and record review, the facility failed to inform patients of the the right to file an internal or external grievance without reprisal or denial of services and that grievances could be filed personally, anonymously, or through a representative for 2 of 4 patients. (#3,#2) Findings include: An interview with the unit receptionist on 11/19/08 revealed the facility had an admission packet that contained consents and information for all patients. This packet included an acknowledgement form that was to be signed by the patient to indicate the patient had received the grievance process information. Patient #3 was admitted to the facility 1/06/02. There was no signed acknowledgements in her clinical record to demonstrate that she had received the facility's external grievance procedures. Patient #2 was admitted to the facility on 3/7/06. Interview with Patient #2 on 11/18/08, revealed the patient was not aware she could voice a concern or grievance anonymously or without reprisal. Observations of the lobby area on 11/17/08, 11/18/08, 11/19/08 and 11/20/08, revealed no posted information regarding the grievance policy. An interview with the Administrator at 8:00 AM on 11/20/08, revealed the posted grievance information had been removed from the lobby.	V 467		
V 470	494.70(c) POSTING OF RIGHTS	V 470		

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V 470	Continued From page 18 The dialysis facility must prominently display a copy of the patient's rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prominently post a copy of the patient rights in the facility. Findings include: Observations of the facility on 11/17/08 through 11/21/08 failed to reveal patient rights were posted anywhere in the facility, either in the public areas or the clinical care unit. An interview with the Administrator at 8:00 AM on 11/20/08, revealed the posted patient information was removed from the lobby.	V 470		
V 506	494.80(a)(3) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] Immunization history, and medication history. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that patients were screened for tuberculosis in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC) for testing for tuberculosis for 1 of 4 patients. (#2)	V 506		

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V 506	Continued From page 19	V 506		

Findings include:

Patient #2 was admitted to the facility on 3/7/06. Review of the clinical record revealed a "Consent for/or Declination of Administration of Tuberculin Skin Test" form. The form was signed by Patient #2 on 5/4/07. The reason noted for declining was "declines=always react."

Review of the clinical record revealed that a chest x-ray completed 1/23/07. A subsequent chest x-ray on 10/13/08 was on file. The second x-ray was done in the emergency department because Patient #2 was complaining of nausea. Neither of the chest x-rays identified they were to rule out tuberculosis.
In reviewing the admission forms for the unit, it was noted that the "Consent For Or Declination Of Administration of Tuberculin Skin Test" form included the following verbiage:

"I understand that whether I receive this skin test is entirely up to me. I have had the opportunity to ask and have answered my questions regarding the administration of the test."

The Nurse Manager of the unit was no longer involved with the unit. She was the staff person involved with the screening, testing and documentation of the results.

In an interview with the Regional Administrator on 11/19/08, he concurred that such verbiage inferred that if a patient declined a "TB skin test," no further steps were to be undertaken. There was no evidence that further education was provided to the patient as to the option of a chest

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V 506	Continued From page 20 x-ray in place of the skin test or that the patient was made aware that some type of screening for tuberculosis was necessary. When interviewed on 11/19/08, Employee #2, who was identified as the charge nurse for that particular day, was not aware if patients were required to have results of their tuberculin status prior to dialyzing in the unit.	V 506		
V 509	494.80(a)(6) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] (6) Evaluation of nutritional status by a dietitian. This STANDARD is not met as evidenced by: Based on clinical record review and interviews, the facility failed to provide comprehensive and timely assessments of the nutritional status or of ongoing patient education in the area of nutrition for 1 of 4 patients. (#3) Findings include: Patient #3 was admitted to the facility 1/06/02, with the primary diagnoses of diabetes and end stage renal disease. Review of the dietary assessments revealed the dietician had made dietary recommendations to the dietary plan of care on 2/29/08. This assessment indicated the dietary goals were to increase protein foods, decrease high potassium and phosphorous foods and work with Patient #3 to obtain these goals. Further review of the care plan revealed Patient	V 509		

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V 509	Continued From page 21 #3 did not sign acknowledgement of the these goals until 5/5/08. There was no further documentation that the dietician followed up on her plan to help Patient #3 accomplish these goals. An interview with the Co-medical Director at approximately 11:00 AM on 11/20/08, revealed that the dietician had been absent from the facility due to her husband's unexpected death. The Co-medical Director stated the patients were not having the same dietary education and interventions because of the dietician's family matters. Located in the facility policy and procedure manual was a Education Checklist for various areas of nutrition. Included were the following topics: Diet Handbook, Kidneys: Master Chemists, What is this thing, Nutrition and HD, Nutrition and PD, Video: Good Nutrition, Cookbook, Dining out with confidence, Albumin, A review, What is this thing called Calcijex, Phosphorus/Bone disease prevention, Hematocrit=What is it?, A review of Sodium and you, and Nutritional Review. There was no documentation in the four records reviewed that any of the aforementioned topics were discussed with the patients. There was no documentation of any dietary education being provided. The facility job description for the Registered Dietician stated that an essential duty was to educate the patient and family about the importance of diet.	V 509		
V 556	494.90(b)(1) IMPLEMENTATION OF THE PATIENT PLAN OF CARE The patient's plan of care must-	V 556		

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V 556	Continued From page 22 (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the plan of care was completed by and interdisciplinary team including the patient and signed by the team members for 2 of 4 patients. (#2, #3) Findings include: An interview with the social worker at approximately 11:00 AM on 11/19/08, revealed she did not participate in any formal interdisciplinary team meetings regarding the plan of care for patients. An interview with Patient #2 on 11/18/08, revealed she had never participated in a care conference meeting and did not know what a care plan or plan of care was. She stated she had been coming to the clinic for several years. Her clinical record revealed her current admission date was 3/7/06. Review of the clinical record of Patient #2 revealed her last short term care plan did not have any interdisciplinary team members. This care plan was dated 5/15/08. Review of the clinical record for Patient #3 revealed a short term care plan dated 9/24/08.	V 556		

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V 556	Continued From page 23 The only interdisciplinary team member's signature was the physician's.	V 556		
V 562	494.90(d) PATIENT EDUCATION AND TRAINING The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types. This STANDARD is not met as evidenced by: Based on record interview and patient interview, the facility failed to provide education and hands on training, particularly in the area of emergency measures, for 4 of 4 patients. (#1, #4, #2, and #3) Findings include: Patient #1 was admitted to the facility on 12/12/07 with diagnoses of end stage renal disease and insulin dependent diabetes. An interview was conduced with the patient at 6:05 AM on 11/18/08. The interview revealed that she had not been instructed in clamping and cutting her lines in case of an emergency. She further revealed that she had not participated in any type of an emergency drill, for fire or other type of diaster. When asked about fistula care, Patient #1 replied that the only thing that she had been instructed in was to check daily for a "thrill." There was no documentation in her record of any ongoing educational process.	V 562		

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V 562	Continued From page 24 Patient #4 was admitted to the facility on 8/22/05 with diagnoses of end stage renal disease due to diabetes. He had also experienced an amputation of a lower extremity. He had been septic on several occasions and frequently had fluid overload. With the exception of diaster preparedness, there was no documentation of any educational processes. Patient #2 had been a patient since March 2006. An interview with Patient #2 at approximately 8:00 AM on 11/18/08, revealed she did not know the process to clamp and cut. Clamp and cut is a procedure that is to be used in case of emergencies such as a fire or other reasons requiring rapid evacuation from the dialysis machine. Patient #2 stated she had been a patient for several years. She stated she may have been instructed initially but did not remember the procedure. No monthly education record was found in Patient #2's chart. There was no evidence of the last time that she was instructed in this procedure. An interview with the charge nurse at approximately 8:30 AM on 11/18/08, revealed any teaching should have been in Patient #2's chart. Patient #3 was admitted on 1/7/02. A review of the clinical record for Patient #3 revealed a form titled "Annual Patient Education Acknowledgement Record." This form was for monthly education for 2007. There was evidence that a clamp and cut procedure was taught on 9/7/07. There was no further education record for 2008.	V 562		
V 680	494.140 PERSONNEL QUALIFICATIONS	V 680		

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V 680	Continued From page 25 This CONDITION is not met as evidenced by: The facility: the facility failed to ensure employee competency (V0681); failed to ensure the presence of a qualified and involved nurse manager (V0684); failed to have an adequate and comprehensive training program for patient care technicians (V0693); and failed to have proof of adequate training for the water treatment technicians (V0696). The cumulative effect of these systemic practices resulted in the failure of the agene to deliver statutorily mandated care to its patients.	V 680		
V 681	494.140 PERSONNEL QUALIFICATIONS All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions. This STANDARD is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to provide documented evidence that employees were competent to meet the needs of patients for 2 of 5 employees (#2, #3) and failed to provide direction and follow-up for a negative annual evaluation for 1 of 5 employees. (#3) Findings include: Employee #2's date of hire was 9/15/08. Review	V 681		

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V 681	Continued From page 26 of her personnel record on 11/20/08, revealed no evidence of any skills check list . A form titled "Cover Page for Personnel File" indicated when information or evaluations were completed. Section 4: Education included an orientation skills checklist. This section had no dates of completion. There was no evidence of emergency procedures or infection control training specific to the facility. A job description for Employee #2 was signed 11/19/08. Employee #3's date of hire was 3/5/07. The form titled "Cover Page for Personnel File" indicated when information or evaluations were completed. This form was blank for all sections. An annual skills checklist was completed 7/28/08, but there was no evidence of an initial skills checklist done in 2007. Employee #3's annual evaluation on 4/22/08, indicated there were some areas that required improvement but there was no plan for improvement or monitoring.	V 681		
V 684	494.140(b)(1) NURSING SERVICES Nurse manager. The facility must have a nurse manager responsible for nursing services in the facility who must- (i) Be a full time employee of the facility; (ii) Be a registered nurse; and (iii) Have at least 12 months of experience in clinical nursing, and an additional 6 months of experience in providing nursing care to patients on maintenance dialysis. This STANDARD is not met as evidenced by:	V 684		

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V 684	Continued From page 27 Based on staff interview, the facility failed to have a nurse manger. Findings include: In an interview with Employee #2 at approximately 1:30 PM on 11/17/08, it was found that a Nurse Manager was not currently available for the facility. The Nurse Manger had been absent from the facility for approximately four to six weeks. The employee thought that the nurse manager was on "family sick leave." On 11/18/08, in an interview with the Regional Administrator, he confirmed that the Nurse Manager had not been at the facility since early October and that she would not be returning. The corporation was in the process of recruiting for a replacement for the position. The current oversight was being provided jointly by two charge nurses who directed ancillary staff and patient care on the days that one or the other worked. A Corporate Nurse Manager from another site provided consultation via phone as the charge nurses deemed necessary. The consulting Nurse Manager had made a two day visit to the facility since the absence of a permanent Nurse Manager. The supporting responsibilities of a Nurse Manager, an ongoing infection control program, staff education, monitoring of mandated vaccines and immunizations, and monitoring of an employee in the patient care technician training program, were not being pursued.	V 684		
V 693	494.140(e)(3) PATIENT CARE DIALYSIS TECHNICIANS [Patient care dialysis technicians must-] (3) Have completed a training program that is	V 693		

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V 693	Continued From page 28	V 693		

approved by the medical director and governing body, under the direction of a registered nurse, focused on the operation of kidney dialysis equipment and machines, providing direct patient care, and communication and interpersonal skills, including patient sensitivity training and care of difficult patients.

This STANDARD is not met as evidenced by:
Based on personnel file review, policy review and staff interview, the facility failed to provide a comprehensive training program under the direction of a registered nurse.

Findings include:

Employee #1 was hired by the facility in August 2008 as a Patient Care Technician (PCT) trainee. She was to be trained in the facility's training program.

In a telephone interview with Employee #1 at 3:30 PM on 11/19/08, the employee related that on the second day of her employment, the nurse manager left the facility. The employee was not aware of which of the two remaining registered nurses were to oversee her training. At the onset of her training, she was assigned to a peer mentor for the clinical portion of her training. After several weeks, that mentor was out on sick leave The employee was then monitored by another trained PCT. Employee #1 stated that she had completed approximately 2/3 of the training modules, mostly on-line and had taken the accompanying post tests. She stated that she had not received any feedback as to the results of the tests. She was not given any timeline or expectation of how long the training should take

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	292516	A. BUILDING _____ B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIALYSIS CLINIC INC - ELKO	1995 ERRECART BLVD 100 - 101 ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 693	Continued From page 29 for completion. She had not undertaken any direct patient care with the exception of "holding sites." An interview was conducted with Employee #6 on 11/19/08, the last mentor involved with the training program for Employee #1. The employee stated that she was not given any schedule as to what was to be done with the trainee. She was not aware of how to document the time spent with the trainee or how to document the results of return demonstrations. A training manual with the core curriculum was found in the employees lounge. It did not include any time schedule for training or forms for documentation of hours spent in training or in clinical practice. Employee #1's personnel file had evidence of post tests for the history of dialysis, ethics and confidentiality, basic anatomy, symptoms of renal failure, modes of therapy, renal nutrition, confidentiality of records, infections, fistulas and grafts, safe administration of medications, and Epogen coverage. There was no evidence that the tests had ever been "graded" nor was there any documentation indicating the successful completion of a module. Employee #1 stated that she had not been told that, within 18 months of her hire date, she would need to be certified under an approved state or national certification program. Approximately thirty-five more areas of study remained to be completed in the required curriculum.	V 693		
V 696	494.140(f) WATER TREATMENT SYSTEM TECHNICIANS Technicians who perform monitoring and testing of the water treatment system must complete a training program that has been approved by the	V 696		

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V 696	Continued From page 30 medical director and the governing body. This STANDARD is not met as evidenced by: Based on personnel training records and interviews, the facility failed to provide documentation that any of the Patient Care Technicians that were responsible for the water system had completed a training program for 2 of 2 employees. (#5, #6) Findings include: Review of the Patient Care Technicians personnel records, Employees #5 and #6, failed to reveal evidence the technicians had been instructed in the water system used for dialysis. A telephone interview with Employee #7 (the Bio-Tech) at 10:00 AM on 11/19/08, revealed that the equipment representative had been out and spent two days instructing the technicians on the water system. Evidence of this training was not available at the end of the survey.	V 696		
V 713	494.150(b) RESPONSIBILITIES OF THE MEDICAL DIRECTOR [Medical director responsibilities include, but are not limited to, the following:] (b) Staff education, training, and performance. This STANDARD is not met as evidenced by: Based on staff record review and interviews, the facility failed to include staff training as part of the Medical Director's responsibilities. Findings include: In an interview with the Co-medical Director at	V 713		

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V 713	Continued From page 31 approximately 10:00 AM on 11/20/08, it was found that the Medical Director did not review the results of the training provided by the facility for the Patient Care Technicians. The Co-medical director did not participate in the decision making process that the trainee was sufficiently trained, had the mandated number of classroom and clinical hours, and was clinically competent to provide safe and efficient care to the facility's dialysis patients.	V 713		
V 760	494.180(b)(3) ADEQUATE NUMBER OF QUALIFIED/TRAINED STAFF [The governing body or designated person responsible must ensure that-] (3) All staff, including the medical director, have appropriate orientation to the facility and their work responsibilities; This STANDARD is not met as evidenced by: Based on review of five personnel records and interviews with staff, the facility failed to provide evidence that four of five direct patient care staff received appropriate orientation to the facility and their work responsibilities. (#2, #3, #4, #5) Findings include: Employee #2 was hired 9/15/08. Review of her personnel file revealed no evidence of a signed job description or orientation. There was no evaluation of her competency skills level, no evidence of emergency procedures or infection control training. An interview with Employee #2 on 11/18/08 revealed that the Nurse Manager went on medical leave the second day of Employee #2's	V 760		

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V 760	Continued From page 32 employment, resulting in an unstructured orientation. Employee #3 was hired 3/5/07. Review of her personnel file revealed no evidence of a signed job description or orientation. The file lacked evidence of an evaluation of her competency skill level or evidence of emergency procedures or infection control training. Employee #4 was hired 12/3/07. Review of her personnel file revealed no evidence of emergency procedures or infection control training. Employee #5 was hired 5/10/07. Review of her personnel file revealed no evidence of emergency procedures training.	V 760		